

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02450

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		b. COUNTY	
Wicomico		Maryland		Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Salisbury				Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Pen Gen. Hospital		107 Fook St			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		Month Day Year	
First Middle Last SARAH CATHERINE BAILEY		FEBRUARY 7th 19 61			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Female		White			
8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days	
May 12, 1870		90 yrs.		8 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House Work		None		Powellville, Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U S A		Hillary Bailey		Mary Ellen Parsons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No				Mrs. Nellie A. Kennerly (Sister) 400 Newton Terrace Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c)		Branch pneumonia		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Fracture R. Humerus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall at home		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Jan 30 1961	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Salisbury Wicomico Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D.		FEB 9 1961	
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 10/1961		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park Salisbury, Maryland	
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR FEB 14 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF RECORDS AND STATISTICS

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, NEW YORK

ALBANY, N.Y.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2481

CERTIFICATE OF DEATH

Reg. Dist. No.

02457

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rumbley</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>19X-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Harold Beauchamp</u>				4. DATE OF DEATH Month Day Year <u>February 20 - 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 18, 1889</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Month Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold Beauchamp</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-01-0903</u>		INFORMANT Address <u>Mrs. Hazel Beauchamp Princess Anne, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>General Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>450.10</u> DUE TO (c) <u>Yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2:20</u> , 19 <u>61</u> , to <u>2:20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2:20</u> , 19 <u>61</u> , and that death occurred at <u>10:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. P. Briele</u>		ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury, Md.</u> DATE SIGNED <u>2-20-61</u>					
PHYSICIAN'S NAME (Type) <u>H. P. Briele</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2-23-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fairmount, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis B. Miller</u>		ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1911

Decemner

Marjorie

Rumley

1911

George Harold

Jan. 18, 1888

Marjorie

Western

Married

Female Form

Married

Harold

214-01-0604 Mrs. Harold Marjorie Trinneer Anne, nee

no

no.

Trinneer Anne, nee

2-22-1901

Trinneer Anne, nee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 5/58

2482

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 FilmG282 3-14-61 et
CERTIFICATE OF DEATH

Reg. Dist. No.

02458

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. STREET ADDRESS <u>? Evans Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Beckett</u>				4. DATE OF DEATH Month Day Year <u>February 26-1961</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1906</u>			
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico Co</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Thomas Beckett</u>				14. MOTHER'S MAIDEN NAME <u>Lucie Robinson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>215-26460</u>		INFORMANT Address <u>Earl Beckett</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>multiple cerebral hemorrhages.</u> DUE TO <u>meningitis (viral)</u> (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:50</u> A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Carrie Hearn</u>				ADDRESS (Street, city or town, state) <u>226 N. Derismond Salisbury Md.</u>					
PHYSICIAN'S NAME (Type) <u>CARRIE HEARN</u>				DATE SIGNED <u>2/27/61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-2-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Falks Rd Cem</u>			
22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks McLeod</u>				ADDRESS <u>Salisbury</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>									

CERTIFICATE OF DEATH

A

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1925

1925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

2483

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02459

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 Wk.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS 1013 Smith St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last James Mitchell Bennett				4. DATE OF DEATH Month Day Year 2 17 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Sup				10b. KIND OF BUSINESS OR INDUSTRY Education			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Issac Bennett				14. MOTHER'S MAIDEN NAME Laura Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-36-6530		17. INFORMANT Mrs. J.M. Bennett, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Generalized carcinomatous DUE TO (c) Interval between onset and death 1 1/2 yr 6 mon				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 2-10 1961 to 2-17 1961 , that (I) (we) last saw the deceased alive on 2-17 1961 , and that death occurred at 12:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE H. Hill				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/20/1961		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland				25a. REC'D BY REGISTRAR DATE FEB 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CERTIFICATE OF DEATH

Reg. Dist. No.

2484

02461

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>23X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Berlin</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS HENRY Cathel</u>				4. DATE OF DEATH Month Day Year <u>February 16 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 16, 1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD. RFD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>			
13. FATHER'S NAME <u>JOHN HENRY CATHOLL</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLEN DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-36-1128</u>			
17. INFORMANT <u>Mrs. T. H. Cathell</u>				Address <u>BERLIN MD RFD 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-12</u> , 19 <u>61</u> , to <u>2-16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-16</u> , 19 <u>61</u> , and that death occurred at <u>3:26 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Silvers</u>				ADDRESS (Street, City or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>2/16/61</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/19/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboze</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

WITNESSES

SIGNATURE

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TIME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2485
CERTIFICATE OF DEATH
02462

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. LENGTH OF STAY IN 1b 40 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First LOUIS Middle AUGUST Last CISSEL		4. DATE OF DEATH Month 2 Day 21 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1895
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 2 Days 21 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Antiques		10b. KIND OF BUSINESS OR INDUSTRY Dealer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Cissel		14. MOTHER'S MAIDEN NAME Mary Ziegler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Army		16. SOCIAL SECURITY NO. 220-32-0696	
17. INFORMANT Mrs. L.A. Cissel, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease & Aortic insufficiency DUE TO (c) 10 yrs + INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/1 19 58 , to death 19 61 , that (I) (we) last saw the deceased alive on 2/15 19 61 , and that death occurred at 1:15 P. , from the causes and on the date stated above.			
22a. SIGNATURE Ernest M. Larmore		22b. DATE SIGNED 2-23-1961	
22c. PHYSICIAN'S NAME (Type) Ernest Larmore		22d. ADDRESS Delmar, Del.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/23/1961	
23c. NAME OF CEMETERY OR CREMATORY St. Philip's Cemetery		23d. LOCATION (City, town, or county) (State) Quantico, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE FEB 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

3884

Name of deceased		Sex		Age		Date of birth	
John Doe		Male		45		Jan 1, 1900	
Place of birth		Cause of death		Date of death		Time of death	
New York City		Heart disease		Jan 15, 1945		10:30 AM	
Occupation		Signature of physician		Signature of registrar		Signature of informant	
Teacher		[Signature]		[Signature]		[Signature]	
Address		City		State		County	
123 Main St		New York		New York		New York	
Telephone		Municipality		County		State	
[Number]		New York		New York		New York	
Municipality		County		State		Country	
New York		New York		New York		United States	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2486

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02463

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last DAVID WILLIAM DENNIS				4. DATE OF DEATH Month Day Year FEB. 4th 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1895		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William K. Dennis				14. MOTHER'S MAIDEN NAME Ella Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W.II		17. INFORMANT Address Mrs. Myrtle R. Dennis (Wife) Powellville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO (b) 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Emphysema INTERVAL BETWEEN ONSET AND DEATH 151X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. N/A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 1-25 6:10 P.M. 2-4 1961 that (II) (we) last saw the deceased alive on 2-4 1961 , and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE Wilber R. Ellis Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 6 / 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Jr.				22d. ADDRESS Medical Center - Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 7, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION (City, town, or county) (State) Powellville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR FEB 8 '61	
						25b. REGISTRAR'S SIGNATURE Charles S. Hume	

CERTIFICATE OF DEATH

5-2-58

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Declaration		Place of Declaration	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH <i>Item 8, Film G-282 3/8/61.cae.</i> </div>																	
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Road				d. STREET ADDRESS 1 Spring Hill Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS ANTHONY ESSIG				4. DATE OF DEATH Month Day Year FEBRUARY 26th 1961													
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1883		9. AGE (In years last birthday) 77 yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator-Equipment Store				10b. KIND OF BUSINESS OR INDUSTRY Westminster Maryland		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A									
13. FATHER'S NAME George Essig				14. MOTHER'S MAIDEN NAME XXXXXXXXX Elizabeth Schneider													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mable Cross Essig (Wife) Spring Hill Road Salisbury, Maryland													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition and anemia 177X DUE TO (b) Cerebrovascular Accident (Embolic) 2 weeks? (c) Carcinoma of prostate, metastatic 2 yrs. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 6 mos									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <table border="1"> <tr> <td>20c. TIME OF INJURY Hour o. m. p. m. N/A 19</td> <td>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></td> <td>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A</td> <td>20f. (City or town) N/A</td> <td>(County)</td> <td>(State)</td> </tr> </table>						20c. TIME OF INJURY Hour o. m. p. m. N/A 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	20f. (City or town) N/A	(County)	(State)		
20c. TIME OF INJURY Hour o. m. p. m. N/A 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	20f. (City or town) N/A	(County)	(State)												
21. I certify that (I) (this hospital) attended the deceased from Feb 12, 1961 12:55 P.M. to Feb 21, 1961 12:55 P.M. that (I) (we) last saw the deceased alive on 2/19/61 and that death occurred at M. from the causes and on the date stated above.																	
22a. SIGNATURE Rufus S. Gardner Jr.				22b. ADDRESS Pine Bluff Rd. Salisbury, Maryland		22c. PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Jr											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 1/1961		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town, or county) Salisbury, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE FEB 28 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kinn									

02464

OFFICE OF THE ATTORNEY GENERAL

1910

IN SENATE

January 10, 1910

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

ON JANUARY 11, 1909

ALBANY: JAMES B. LEECH, STATE PRINTER, 1910.

THE STATE OF NEW YORK.

OFFICE OF THE ATTORNEY GENERAL.

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ON JANUARY 11, 1909

ALBANY: JAMES B. LEECH, STATE PRINTER, 1910.

1. NAME
2. ADDRESS
3. CITY
4. STATE
5. ZIP
6. PHONE
7. FAX
8. TELETYPE
9. CABLE
10. RADIO
11. TELEVISION
12. MAGAZINES
13. BOOKS
14. RECORDS
15. FILMS
16. PHOTOGRAPHS
17. CARDS
18. CLIPPING
19. OTHER

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02466

2489

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 321 E. Locust St		d. STREET ADDRESS 321 E. Locust St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle ELMER Last FITZGERALD		4. DATE OF DEATH Month FEBRUARY Day 2nd Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1899
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10 Hours Min. 	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee- Roofing Co. Laborer		10b. KIND OF BUSINESS OR INDUSTRY Quantico Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Fitzgerald		14. MOTHER'S MAIDEN NAME Alice Ingersoll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Lillian Fitzgerald (Wife)		Address 321 E. Locust Street Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Cardiac insufficiency DUE TO (b) Cirrhosis of Liver DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A 19 19 p. m. N/A		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from Jan 2:15P to 2-2 19 61 , that (I) (we) last saw the deceased alive on 2-2 19 61 , and that death occurred at 2:15P M, from the causes and on the date stated above.			
22a. SIGNATURE W. B. Smith		22b. DATE SIGNED Feb. 5 / 1961	
22c. PHYSICIAN'S NAME (Type) Dr. William Smith		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 5, 1961	
23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery (Walston) R.D. #		23d. LOCATION (City, town, or county) (State) Salisbury, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR DATE FEB 8 '61	
ADDRESS SALISBURY MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

2281

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Duration of illness

8. Name of attending physician

9. Name of informant

10. Signature of informant

11. Signature of physician

12. Signature of registrar

13. Name of registrar

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177. Name of registrar

178. Signature of registrar

179. Signature of registrar

180. Signature of registrar

CERTIFICATE OF DEATH

1911

1. Name of deceased John J. Smith

2. Sex Male

3. Age 45

4. Date of death Jan 15 1911

5. Place of death at home

6. Cause of death Heart Disease

7. Signature of physician Dr. J. H. Jones

8. Signature of registrar Wm. H. Smith

9. Date of registration Jan 16 1911

10. Place of registration Boston

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

(M)

X

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
2491					02468									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)									
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE			b. COUNTY						
Wicomico			Delmar		Maryland			Wicomico						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
205 E. Chestnut St					1209 Railroad Ave.									
3. NAME OF DECEASED (Type or print)			First			Middle			Last					
			IDA			MARSHALL			GORDY					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White				May 12, 1868		92 yrs.		Months 9 Days 11 Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?				
House work at home				None		Sussex Co. Delaware				U S A				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Marshall Smith					Laura Hall									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
No										Mrs. Fannie Ruth Allen (Daughter) 205 E. Chestnut St. Delmar, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary artery occlusion (c) coronary arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Arteriosclerosis generalized - Basal cell Ca 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Interval between onset and death: 2 weeks 2 weeks ?														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) neck. N/A										
20c. TIME OF INJURY			Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
Hour a. m. p. m.			N/A 19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		N/A		N/A					
21. I certify that (I) (this hospital) attended the deceased from 1956 to Feb 23, 1961, that (I) (we) last saw the deceased alive on Feb 23, 1961, and that death occurred at 2:10 A.M. from the causes and on the date stated above.														
22a. SIGNATURE					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					Feb. 24 / 1961				
Dr. L.V. Sohler					Delmar, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)					
Burial			Feb. 26, 1961		Parsons Cemetery				Salisbury, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
HOLOWAY & COMPANY					SALISBURY MARYLAND					DATE FEB 27 '61		Charles L. Kinner		

CERTIFICATE OF DEATH

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CHESTERMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2492										02469																			
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)																			
a. COUNTY Wicomico					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela					c. LENGTH OF STAY IN 1b 6 Months					d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
a. STATE Md.					b. COUNTY Wicomico					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown, Md.					d. STREET ADDRESS Main St.														
3. NAME OF DECEASED (Type or print) Lucy Windsor Gravenor										4. DATE OF DEATH Feb 4 1961																			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 20, 1872				9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY None					11. BIRTHPLACE (State or foreign country) Md.					12. CITIZEN OF WHAT COUNTRY? U. S.														
13. FATHER'S NAME George C. Windsor										14. MOTHER'S MAIDEN NAME Nancy Russell																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. None					17. INFORMANT Lester Windsor Camden Court, Salisbury Md.																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Bronchitis DUE TO Arterio Sclerotic Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arterio Sclerotic General PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 10 days 8 years 12 years																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from Jan 25 1961 to Feb 4 1961 , that (I) (we) last saw the deceased alive on Jan 25 1961 , and that death occurred at 59 A.M. from the causes and on the date stated above.																													
22a. SIGNATURE H. S. Kuhlman										22b. DATE SIGNED Feb 4 1961																			
22c. PHYSICIAN'S NAME (Type) H. S. Kuhlman										22d. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Feb 7, 1961					23c. NAME OF CEMETERY OR CREMATORY Firemens					23d. LOCATION (City, town, or county) (State) Sharptown, Md.														
24. FUNERAL DIRECTOR'S SIGNATURE Smith										25a. REC'D BY REGISTRAR FEB 7 '61										25b. REGISTRAR'S SIGNATURE Arthur S. Jones									

2183

STATE OF TEXAS

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

STATE OF TEXAS

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

STATE OF TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
2493												
02470												
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> ✓						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. LENGTH OF STAY IN 1b <u>1 day.</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>						d. STREET ADDRESS <u>BERLIN VINE ST 23X-2</u>						
3. NAME OF DECEASED (Type or print) <u>John L. Hammond</u>						4. DATE OF DEATH <u>February 1 - 1961</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 5, 1889</u>		9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEAT DEALER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>				11. BIRTHPLACE (State or foreign country) <u>WHALEYVILLE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>J. FRANKLIN HAMMOND</u>						14. MOTHER'S MAIDEN NAME <u>LOUISE TAYLOR</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR</u>						16. SOCIAL SECURITY NO. <u>WORLD WAR</u>						
17. INFORMANT <u>MRS. J. L. HAMMOND</u>						Address <u>BERLIN MD</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>451X</u> DUE TO <u>Rupture of Aneurysm Abdominal Aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of Aorta</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1</u> 19 <u>61</u> to <u>Feb. 1</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb. 1</u> 19 <u>61</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.												
22a. SIGNATURE <u>Hand J. Gilman</u>						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type)			
22d. ADDRESS						22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>2/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>				23d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>						ADDRESS <u>Berlin Md.</u>			25a. REC'D BY REGISTRAR DATE <u>FEB 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE COMMISSIONER
BUREAU OF VITAL STATISTICS
ALBANY, N. Y.

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April 21st 1911

Post Office, New York City, N. Y.

Louis Taylor

J. Franklin Harmon

Mr. J. Harmon, Beacon Mt.

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APR 21 1911
BUREAU OF VITAL STATISTICS
ALBANY, N. Y.

2494

CERTIFICATE OF DEATH

Reg. Dist. No. 02471

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u>		2342-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>105 FOURTH STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND F. HANCOCK</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY 5 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 27 1880</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT W. HANCOCK</u>				14. MOTHER'S MAIDEN NAME <u>LAURA REDDEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>227-20-4004A</u>		INFORMANT Address <u>MILTON S. HANCOCK, Pocomoke City, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>Centuries</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-31</u> , 19 <u>61</u> , to <u>2-5</u> , 19 <u>61</u> that I last saw the deceased alive on <u>2-5</u> , 19 <u>61</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury Md. 2-6-61</u>							
ACTUAL SIGNATURE <u>W. R. ELLIS JR.</u>		PHYSICIAN'S NAME (Type) <u>W. R. ELLIS JR.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-8-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GOODWILL METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL-POCOMOKE CITY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>				ADDRESS <u>POCOMOKE CITY, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2495
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02472

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u> 46 X 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>Pine St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETTA</u> <u>Mar</u> <u>Hardesty</u>		4. DATE OF DEATH <u>February</u> <u>2</u> 19 <u>61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1st 1890</u>		
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Seaford, Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William S. Burton</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>Richard B. Hardesty</u> Address <u>507 Hickory Lane, Seaford, Del</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u> 201X DUE TO <u>Bone Marrow Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hodgkins Disease</u> DUE TO (c) <u>Hodgkins Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>22 das</u> <u>22 das</u> <u>3 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> 19 <u>61</u> to <u>2/2</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/2</u> 19 <u>61</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above.					
22a. SIGNATURE <u>Rufus S. Gardner Jr</u> M.D.		22b. DATE SIGNED <u>2/2/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		22d. ADDRESS <u>Pinebluff Rd., Seaford, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 4, 1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		23d. LOCATION (City, town, or county) (State) <u>Seaford Delaware</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry E. Darby</u> ADDRESS <u>300 Shipley St, Seaford Del</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
DATE <u>FEB 6 '61</u>					

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
2496 CERTIFICATE OF DEATH 02473									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital					d. STREET ADDRESS 301 Quincy St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MASON Middle WRIGHT Last HILL SR.					4. DATE OF DEATH Month FEBRUARY Day 20 Year 1961				
5. SEX Male		6. COLOR OR RACE White		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1902		9. AGE (In years last birthday) yrs. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Sussex Co. Delaware			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Henry Hill					14. MOTHER'S MAIDEN NAME Mary Milbourne				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary E. Hill (Wife) Address 301 Quincy St Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 260 X IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A							
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A 19 p. m. N/A		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A			
21. I certify that (I) (this hospital) attended the deceased from 8/29/58 19____ to 2/20/61 19____, that (I) (we) last saw the deceased alive on 2/20/61 19____, and that death occurred at ____ M., from the causes and on the date stated above.									
22a. SIGNATURE Dr. Andrew C. Mitchell					22b. DATE SIGNED Feb. 22 / 1961		22c. ADDRESS Maryland Ave. Salisbury, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 23, 1961		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR FEB 24 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

STATE OF NEW YORK
CERTIFICATE OF DEATH

10

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15 1910*
5. Place of death: *New York City*
6. Cause of death: *Heart Disease*
7. Signature of physician: *John Doe*
8. Signature of registrar: *John Doe*
9. Date of registration: *Jan 15 1910*
10. Place of registration: *New York City*

CERTIFICATE OF DEATH

Reg. Dist. No.

02474

2497

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Perlie Middle Jones Last Jones				4. DATE OF DEATH Month February Day 8 Year 1961			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 18, 1886	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO		16. INFORMANT Address Dorothy Hardy-Pocomoke, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident (thrombosis) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 18 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 21, 1961 to February 8, 1961 , that I last saw the deceased alive on Feb 7, 1961 , and that death occurred at 8:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Feb. 8, 1961							
ACTUAL SIGNATURE Robert T. McKis M.D.				DATE SIGNED Feb. 8, 1961			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-61		22c. NAME OF CEMETERY OR CREMATORY R.B. Wharton Memorial		22d. LOCATION (City, town, or county) (State) Banksville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - new church, Va.				24a. REC'D BY REGISTRAR DATE FEB 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1885

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2498
CERTIFICATE OF DEATH
02475

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Parsonsburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 (Wango)		d. STREET ADDRESS R.D.# 1 (Wango)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEAH Middle CATHERINE Last LAWS		4. DATE OF DEATH Month FEBRUARY Day 11th Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1864
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) R.D.# Parsonsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George W. Jarman		14. MOTHER'S MAIDEN NAME Sarah Ann Brittingham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Mrs. Margaret Walker (Daughter) Berlin, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Degenerative heart disease DUE TO (b) 3 yr. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. N/A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 5/2 to 2/11 , 19 61 , that (I) (we) last saw the deceased alive on 2/10 , 19 61 , and that death occurred at 10:30p M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Earl M. Beardsley		22b. DATE Feb. 13 / 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Earl M. Beardsley		22d. ADDRESS Maryland Ave. Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 14, 1961	
23c. NAME OF CEMETERY OR CREMATORY Laws Family Cemetery		23d. LOCATION (City, town, or county) (State) R.D.# Parsonsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR Feb 14 '61	
ADDRESS SALISBURY MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur L. King	

1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2499

CERTIFICATE OF DEATH

02476

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 30 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403 S. Div. St.,		d. STREET ADDRESS 403 S. Div. St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle VIRGINIA Last LIVINGSTON		4. DATE OF DEATH Month 2 Day 25 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josephus Chatham		14. MOTHER'S MAIDEN NAME Drucilla Messick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Wm. S. Martin, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1960 to 2/25 19 61 , that (I) (we) last saw the deceased alive on 2/25 19 61 , and that death occurred at 6:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Fred R. Gramse		22b. DATE SIGNED 2-27-1961	
22c. PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse		22d. ADDRESS South Division St., Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-28-61	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co		25a. REC'D BY REGISTRAR FEB 28 '61	
ADDRESS Salisbury, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Krawitz	

MINISTRY OF NATIONAL DEFENSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2500

CERTIFICATE OF DEATH

02477

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Rural		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela	
3. NAME OF DECEASED (Type or print) Zilda Ellis Lord First Middle Last		4. DATE OF DEATH Month February Day 24 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas J. Ellis		14. MOTHER'S MAIDEN NAME Annie Birley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs. Bertie Wheatley, Laurel, Delaware			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 502.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO Chronic Bronchitis (c) 1 Year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 3, 1960 to Feb 24, 1961 , that (I) (we) last saw the deceased alive on Feb 24, 1961 , and that death occurred at P. M. , from the causes and on the date stated above.			
22a. SIGNATURE H. S. Kuhlman		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) H. S. Kuhlman		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-26-61	
23c. NAME OF CEMETERY OR CREMATORY Galestown		23d. LOCATION (City, town, or county) (State) Galestown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Smith Funeral Home		ADDRESS Sharptown, Md.	
25a. REC'D BY REGISTRAR DATE FEB 28 '61		25b. REGISTRAR'S SIGNATURE Arthur L. House	

CERTIFICATE OF DEATH

1000

CHIEF CLERK

DEPT. OF HEALTH

NOV 1914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2501

CERTIFICATE OF DEATH

Reg. Dist. No. 02478

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Luzern			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 14 mOs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Sanatorium				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dallas			
				d. STREET ADDRESS Center Hill Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Charlotte Warman Mac Veigh				4. DATE OF DEATH Month Day Year Feb. 27 1961			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1886	
9. AGE (In years last birthday) 74 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Salida, Colorado		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Cy Warman				14. MOTHER'S MAIDEN NAME Ida Hayes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. J.H. Mac Veigh				Address Dallas, Paon.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Jan 1961 to Feb. 27, 1961 , that I last saw the deceased alive on Feb. 26, 1961 , and that death occurred at 10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Salmon				M.D. Salisbury Md.			
PHYSICIAN'S NAME (Type)				DATE SIGNED Feb. 28, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-28-61		22c. NAME OF CEMETERY OR CREMATORY Nanokin Presbyterian		22d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson				ADDRESS Princess Anne, Md.		24g. REC'D BY REGISTRAR DATE MAR 2 '61	
				24b. REGISTRAR'S SIGNATURE Charles S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2502

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02470

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md.		c. LENGTH OF STAY IN 1b Since 2/23/61	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Bluff State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Franklin Last McDorman		4. DATE OF DEATH Month Feb. Day 27 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/1887
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Light House Keeper U.S. Coast Guard		10b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard Dames Quarter, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William McDorman		14. MOTHER'S MAIDEN NAME Lettie Parks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-1516	
17. INFORMANT Records of Pine Bluff State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema 5 27.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis 002X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 23 , 19 61 , to Feb. 27 , 19 61 , that (I) (we) last saw the deceased alive on Feb. 25 , 19 61 , and that death occurred at 2:40 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED Feb. 27, 1961	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-1-1961	
23c. NAME OF CEMETERY OR CREMATORY Charles Cemetery		23d. LOCATION (City, town, or county) (State) Charles Chance, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Princess Anne, Md.		25a. REC'D BY REGISTRAR MAR 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Haus			

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

CONFIDENTIAL

TO : DIRECTOR, FBI (100-371101)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]

100-371101-1216

[Extremely faint and mostly illegible body text, appearing to be a memorandum or report.]

TO HOSPITAL CLERK: This certificate is to be filled out by the attending physician or funeral director. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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2503
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02480

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 9 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanatorium		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS N. Division St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CAROLINE First COOKE Middle McKoy Last		4. DATE OF DEATH Month 2 Day 24 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1869
9. AGE (In years lost birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 15 Days 22 IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Maj. Augustus Buckner Cooke		14. MOTHER'S MAIDEN NAME Sarah A. (Maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Thomas H. McKoy Jr.		18. ADDRESS 1500 Walnut St., Phila., Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 15 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 2-24 19 61 , that (I) (we) last saw the deceased alive on 2-23 19 61 , and that death occurred at 7:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Philip A. Insley		22b. DATE SIGNED 2-25-61	
22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		22d. ADDRESS 116 E Main St., Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial & Removal		23b. DATE THEREOF 2-27-61	
23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		23d. LOCATION (City, town, or county) (State) Norfolk, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland		25a. REC'D BY REGISTRAR MAR 2 '61	
25b. REGISTRAR'S SIGNATURE C. L. H. H. H.			

CERTIFICATE OF DEATH

5200

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

2504

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02461

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Route 2 Jersey Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>		4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 18, 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Cornish</u>		14. MOTHER'S MAIDEN NAME <u>Kizzie Hopkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Elizabeth Chandler Jersey Road</u>	
17. INFORMANT <u>Elizabeth Chandler</u>		Address <u>Salisbury Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Coma</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>260X</u> DUE TO <u>260X</u> (c) <u>260X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cellulitis abdominal wall</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-18</u> to <u>2-2</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> 19 <u>61</u> , and that death occurred at <u>2:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Fligia Lewis</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/5/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>	
ADDRESS <u>Salisbury Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

2501
2502



1

CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Birth: *Jan 1, 1900*

5. Date of Death: *Jan 1, 1945*

6. Place of Birth: *Washington, D.C.*

7. Cause of Death: *Heart Disease*

8. Signature of Physician: *John Doe*

9. Signature of Registrar: *John Doe*

10. Date of Registration: *Jan 1, 1945*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02482

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 20 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 Park Ave.,				d. STREET ADDRESS 507 Park Ave.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) THOMAS HENRY MITCHELL, Jr.				4. DATE OF DEATH 2 9 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1896	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricks Maker				10b. KIND OF BUSINESS OR INDUSTRY Owner			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas H. Mitchell Sr.				14. MOTHER'S MAIDEN NAME Sally Wimbrow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---			
17. INFORMANT Mrs. Thomas H. Mitchell, Jr. Same				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1956 19 to 2/7 19 61 , that (I) (we) lost the deceased alive on 2/7 19 61 , and that death occurred at 2:30 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Fred R. Gramse				22b. DATE SIGNED 2/9/61			
22c. PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse				22d. ADDRESS S. Div. St. Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/11/61			
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery				23d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				25a. REC'D BY REGISTRAR FEB 14 '61			
ADDRESS				25b. REGISTRAR'S SIGNATURE Arthur L. House			

3895

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...

City of ...

State of ...

January ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2506

02483

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>3 1/2 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Hill Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>	
3. NAME OF DECEASED (Type or print) First <i>Joseph A.</i> Middle <i>Molloy</i> Last <i></i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>26</i> , Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/25/1889</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	11. UNDER 24 HRS. Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stock Broker retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Boston, Mass.</i>	
11. BIRTHPLACE (State or foreign country) <i>Boston, Mass.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Molloy</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Herlihy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>065-05-0527</i>	
17. INFORMANT <i>Mrs. Dorothy D. Molloy</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Rupture Disease</i> DUE TO (b) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i></i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i></i> p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>Feb 1</i> , 19 <i>61</i> , to <i>2-26</i> , 19 <i>61</i> , that (I) <i>two</i> last saw the deceased alive on <i>2-15</i> , 19 <i>61</i> , and that death occurred at <i>11:05 PM</i> , from the causes and on the date stated above.	
22a. SIGNATURE <i>Richard A. Insley</i>		22b. DATE SIGNED <i>2/27/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr. I. P. A. Insley</i>		22d. ADDRESS <i>Salisbury Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/1/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat. Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		25a. REC'D BY REGISTRAR <i>MAR 2 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		25c. ADDRESS <i>Chestertown, Md.</i>	

5280

STATE OF OHIO

DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2507

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02484

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Wicimico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Life</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mattie</u> First Middle Last <u>MORRIS</u>				4. DATE OF DEATH <u>February 1, 1961</u> Month Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-16-08</u>			
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. BIRTHPLACE (State or foreign country) <u>Wicimico co.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>					
13. FATHER'S NAME <u>Lenwood Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Maudie Weatherly</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-16-7332</u>					
17. INFORMANT <u>Hayman Morris Quantico, Md</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nervous Breakdown. Heart Disease.</u> 331 X DUE TO (b) <u>Atherosclerosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Unknown</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>6/15</u> <u>1960</u> to <u>2/1</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>2-1-</u> <u>1961</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard H. Saunders</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/2/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS</u>				22d. ADDRESS <u>NANTICORE Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>2-4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Quantico cem.,</u>			
23d. LOCATION (City, town, or county) (State) <u>Quanyico, Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u> ADDRESS <u>Salisbury Md.</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

CERTIFICATE OF DEATH

2507

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
DATE OF DEATH
PLACE OF BIRTH
PLACE OF DEATH
CAUSE OF DEATH
DISEASE
SIGNATURE OF PHYSICIAN
SIGNATURE OF WITNESSES
OFFICIAL CERTIFICATE

CERTIFICATE OF DEATH

Reg. Dist. No. 02485

2508

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>upper Fairmount</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>C</u> Last <u>MOWBRAY</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-1879</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Lee Mowbray</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Banning</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mr. Ida Mowbray upper Fairmount</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G.I. HEMORRHAGE</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA-PROBABLY GASTRIC C</u> DUE TO <u>HEPATIC METASTASES</u> (c) <u>HEPATIC METASTASES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-20-61</u> to <u>2-23-61</u> , that I last saw the deceased alive on <u>2-23-61</u> 19 <u>61</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>James M. Chase, Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>JAMES M. CHASE, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2-25-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairmount Cemetery upper Fairmount</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u> ADDRESS <u>Princeton Ave</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u> DATE <u>MAR 2 '61</u>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8075

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2509

CERTIFICATE OF DEATH

02486

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 10 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 720 S. Park Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lela Middle Schuder Last Payne		4. DATE OF DEATH Month 2 Day 17 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1890
9. AGE (In years lost birthday) 70 1/2 yrs.		10. IF UNDER 1 YEAR Months 7 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Schuder		14. MOTHER'S MAIDEN NAME Clara Strader	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Lewis Payne, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Heart Disease DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Coronary Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension; Rheumatoid Arthritis		INTERVAL BETWEEN ONSET AND DEATH 9 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1952 to Feb 17 1961 , that (I) (we) last saw the deceased alive on Feb 16 1961 , and that death occurred at 7:35 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Leland J. Gilmore		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/20/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Covington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland		25a. REC'D BY REGISTRAR FEB 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Knaus			

CERTIFICATE OF DEATH

5005

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE AT DEATH
SEX
RACE
BIRTH DATE
BIRTH PLACE
MARRIAGE DATE
MARRIAGE PLACE
EDUCATION
OCCUPATION
RELIGION
SIGNED
WITNESSED

1881

Ohio

John Smith

Handwritten signature

Handwritten signature

Handwritten signature

Handwritten signature

2510

CERTIFICATE OF DEATH

Reg. Dist. No.

02487

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Raymond J.</u> Middle <u>PILCHARD</u> Last <u>PILCHARD</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 10 - 1884</u>	
9. AGE (In years last birthday) <u>76 4/13</u>		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Pocomoke City, MD</u>				12. CITIZEN OF WHAT COUNTRY? <u> </u>			
13. FATHER'S NAME <u>Ira Pilchard</u>				14. MOTHER'S MAIDEN NAME <u>Olia Cydilette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>314-34-6192</u>			
17. INFORMANT <u>Mrs. Walter Merritt, Pocomoke City, MD</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stricture of Esophagus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 22</u> , 1960, to <u>Feb. 23</u> , 1961, that I last saw the deceased alive on <u>Feb. 22</u> , 1961, and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr. M.D.</u>				ADDRESS (Street, city or town, state) <u>Pine Bluff Road 2/23/61</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, MD</u>				DATE SIGNED <u>2/23/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 26/61</u>				22b. DATE THEREOF <u>Feb 26/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton J. Smith</u>				24a. REC'D BY REGISTRAR <u> </u> ADDRESS <u> </u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>				DATE <u>FEB 27 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5710

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

2511 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Willoughby Last Porter <i>Jr</i>				4. DATE OF DEATH Month 2 Day 24 Year 61 19			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/26/1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years last birthday) 3 Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME <i>Richard H. Porter</i>				14. MOTHER'S MAIDEN NAME <i>Betty Webster</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Richard H. Porter, Salisbury Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull: crushed chest. 830X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO causing the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 15 min.							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child struck by car pulling out of driveway.			
20c. TIME OF INJURY Month, Day, Year 5:15 P.M. 2-24-61				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard.	
2Df. (City or town) Salisbury				20f. (County) Wicomico		20g. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Earl L. Royer</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 3-2-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried				22b. DATE THEREOF 2/28/61		22c. NAME OF CEMETERY OR CREMATORY East New Market	
22d. LOCATION (City, town, or county) East New Market, Md				22e. (State) Md			
23. FUNERAL DIRECTOR <i>Kurt S. Thoroughly</i>				ADDRESS East New Market		24a. REC'D BY REGISTRAR MAR 9 61	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>							

MEDICAL CERTIFICATION

100-3-1



100-3-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2512

02488

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hosp. Tal.</u>				d. STREET ADDRESS <u>300 JEWEL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ROBERT Powell</u>				4. DATE OF DEATH Month Day Year <u>2 4 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-28-1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DERRICK-ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES POWELL</u>				14. MOTHER'S MAIDEN NAME <u>RACHEL NEEDLES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>716-01-9416</u>		17. INFORMANT Address <u>Blanch Powell-Delmar Del</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of rectum</u> DUE TO (c) <u>unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pt. had local resection of Ca rectum under anesthesia 7 days prior</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>William H. Z. Stumpf</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-7-61</u>		<u>St. Olives</u>		<u>Delmar Del</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Mamel Co - Delmar, Del</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>FEB 7 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1. Name of deceased *John Doe*
2. Sex *Male*
3. Age *45*
4. Date of death *Jan 15 1924*
5. Place of death *Home*
6. Cause of death *Heart Disease*
7. Signature of physician *Dr. J. H. Smith*
8. Signature of registrar *W. H. Taylor*
9. Signature of informant *John Doe*
10. Date of registration *Jan 16 1924*
11. Place of registration *City of New York*
12. Registrar's Office *City of New York*
13. Registrar's Name *W. H. Taylor*
14. Registrar's Address *123 Main St. New York*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																								
2513																								
CERTIFICATE OF DEATH																								
02489																								
1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury					c. LENGTH OF STAY IN 1b 12					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 289 Loblolly Lane					d. STREET ADDRESS 1 289 Loblolly Lane					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First SARAH Middle LOUISE Last SHEAFFER					4. DATE OF DEATH Month FEBRUARY Day 11 Year 1961																			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1904		9. AGE (In years lost birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home					10b. KIND OF BUSINESS OR INDUSTRY None					11. BIRTHPLACE (State or foreign country) Crisfield, Maryland					12. CITIZEN OF WHAT COUNTRY? U S A									
13. FATHER'S NAME Fredrick G. Elmore					14. MOTHER'S MAIDEN NAME Caroline B. Colonna																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. N/A					17. INFORMANT Mr. John S. Sheaffer (Husband) Address 289 Loblolly Lane - Salisbury, Maryland														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) generalized carcinoma DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinoma of Breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) N/A										INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yr														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. N/A 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A					20f. (City or town) (County) (State) N/A									
21. I certify that (I) (this hospital) attended the deceased from April 24, 1960 to February 11, 1961 , that (I) met last saw the deceased alive on February 11, 1961 , and that death occurred at 11:30 AM , from the causes and on the date stated above.																								
22a. SIGNATURE Robert T. Adkins										M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED Feb. 13 / 1961									
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins										22d. ADDRESS Fruitland, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Feb. 15, 1961					23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park					23d. LOCATION (City, town, or county) (State) Salisbury, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY										ADDRESS SALISBURY MARYLAND					25a. REC'D BY REGISTRAR DATE FEB 14 1961					25b. REGISTRAR'S SIGNATURE				

M

X

1

bp

CERTIFICATE OF DEATH

2511

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2511

2511

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2511

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2514 CERTIFICATE OF DEATH 02490											
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland c. LENGTH OF STAY IN b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station, Md. d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elwood First - Middle Sheeche Last						4. DATE OF DEATH Feb. Month 26 Day 19 61 Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 20, 1891		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman				10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel E. Shehee						14. MOTHER'S MAIDEN NAME Lucy Blizzard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Hayes Diggs, Box 701, Crisfield, Md. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 450.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (b) 1 day (c) 10 yrs DUE TO 10 yrs causes last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Tertiary Liver (according to history)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 21, 1961 to Feb. 26, 1961 , that (I) (we) last saw the deceased alive on Feb. 26, 1961 , and that death occurred at 8:40 AM from the causes and on the date stated above.											
22a. SIGNATURE Lee L. Lawry M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 2-26-61		
22c. PHYSICIAN'S NAME (Type) Lee Lawry, M.D.						22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 28, 1961		23c. NAME OF CEMETERY OR CREMATORY CRISFIELD CEMETERY		23d. LOCATION (City, town or county) (State) CRISFIELD, MARYLAND					
24. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW + SONS, CRISFIELD, MD. ADDRESS						25a. REC'D BY REGISTRAR MAR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

Agent M. J. Carroll
Bureau of Customs
1874

Secretary of the Treasury

Wm. L. Carroll

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2515

02491

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>307 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u> d. STREET ADDRESS <u>none</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Wesley Smith</u>		4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1961</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col.</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 22, 1880</u> 9. AGE (In years last birthday) <u>80</u> 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> 11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Barnes</u> 14. MOTHER'S MAIDEN NAME <u>Mammie Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>218-20-3533</u> 17. INFORMANT <u>records Deers Head Hospt. Salisbury</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculous pneumonia</u> DUE TO (b) <u>Abscess of the liver (multiple)</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>April 7, 1960</u> to <u>Feb. 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb. 7, 1961</u> , and that death occurred at <u>1:50 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Lee L. Lawry</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>2/8/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M. D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cemetery</u>			
23d. LOCATION (City, town or county) <u>Preston, Md.</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Williams - Salisbury, Md.</u> ADDRESS <u> </u>					
25a. REC'D BY REGISTRAR <u>FEB 14 61</u> DATE <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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2173

Lee Harvey

10/11/71 - 10/11/71

Lee Harvey

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 905 Hanover St					d. STREET ADDRESS 905 Hanover St				
3. NAME OF DECEASED (Type or print) First ROSA Middle ELLEN Last SMITH					4. DATE OF DEATH Month FEBRUARY Day 2nd Year 19 61				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1870		9. AGE (In years last birthday) 90 yrs. 10. IF UNDER 1 YEAR Months 6 Days 16 11. IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Fruitland, Maryland			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Benjamin Dixon					14. MOTHER'S MAIDEN NAME Catherine Hayman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 		17. INFORMANT Address Mrs. Grace E. Williams (Daughter) 905 Hanover St. Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A						
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 61 p. m.			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A		(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1957 to 2-2 1961 , that (I) (we) last saw the deceased alive on 1-27 1961 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE Philip A. Insley					22b. DATE SIGNED Feb. 6 / 1961		22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		
22d. ADDRESS Main St. Salisbury, Maryland					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb. 4, 1961		23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery - R.D. # Salisbury, Maryland			23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY					ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE FEB 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans

8158

MADE IN U.S.A. AND REPAIRS BY SPECIAL
CERTIFICATE OF QUALITY

MADE IN U.S.A. AND REPAIRS BY SPECIAL
CERTIFICATE OF QUALITY

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2517 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 filed 2-20-61 at

02493

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN lb Pen. Gen. Hospital			
d. NAME OF HOSPITAL OR INSTITUTION (What in hospital, give street address) None Pen. Gen. Hospital				d. STREET ADDRESS Salisbury/ Crisfield			
3. NAME OF DECEASED (Type or print) MARGARET				4. DATE OF DEATH STERLING FEBRUARY 9th 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1872	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wilmington Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME L E.P. Dennis				14. MOTHER'S MAIDEN NAME Rebecca Smith Benson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Records: The John B. Parsons Home for the Aged Salisbury, Maryland		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, spontaneous 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Rt. Femoral Neck				INTERVAL BETWEEN ONSET AND DEATH today year			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell to floor John B. Parsons Home					
20c. TIME OF INJURY Hour a.m. p.m. 7:40 a.m.	Month, Day, Year 12-17-60	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Salisbury	(County) Wicomico	(State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Feb. 10 /1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 12/1961	22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery		22d. LOCATION (City, town, or country) (State) Crisfield, Maryland			
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY MARYLAND				24a. REC'D BY REGISTRAR FEB 14 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thoms	

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MAINTENANCE STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF HEALTH
I, the undersigned, a duly qualified Medical Examiner, do hereby certify that
the within and above named person is a person of good character and
sound mind and body, and is fit to hold the position of _____
and to exercise the duties thereof, and is not suffering from any
communicable disease, and is not addicted to the use of any
habit-forming drug or alcohol, and is not suffering from any
other physical or mental condition which would render him or her
unfit to hold the position of _____ and to exercise the
duties thereof, and is not suffering from any other physical or
mental condition which would render him or her unfit to hold the
position of _____ and to exercise the duties thereof.

WITNESSED my hand and the seal of the Department of Health at
the City of _____, this _____ day of _____, 19____.

Medical Examiner

Secretary of the Department of Health

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2518 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02496											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					c. LENGTH OF STAY IN 1b 3 weeks						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn St.					d. STREET ADDRESS Wenona						
3. NAME OF DECEASED (Type or print) Zack					4. DATE OF DEATH Month 2-3-61 Day 19 Year 19						
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 7-1877		9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR: Months 2 Days 3 IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman					10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CALVIN TAWES					14. MOTHER'S MARDEN NAME EMILY GIBSON						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. NONE		17. INFORMANT VIOLET LACURTS			Address GLENN ST SALISBURY-MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH Years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Earl L. Royer, M.D.					DATE SIGNED 2-4-61						
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 2-5-61		22c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEMETERY		22d. LOCATION (City, town, or country) (State) DEAL ISLAND - MD		
23. FUNERAL DIRECTOR L. G. Webster					ADDRESS Princess Anne		24a. REC'D BY REGISTRAR FEB 7 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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Decedent's Name: _____
Sex: _____
Age: _____

Place of Birth: _____
Date of Birth: _____

Place of Death: _____
Date of Death: _____

Signature of Medical Examiner: _____
Date: _____

Signature of Registrar: _____
Date: _____

Waterman

GALVIN

(1)

Signature of Medical Examiner: _____
Date: _____

Signature of Registrar: _____
Date: _____

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MARYLAND STATE DEPARTMENT OF HEALTH
2519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02495

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stockton			
c. LENGTH OF STAY IN 1b D.O.A.				d. STREET ADDRESS ---			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen E. Tull				4. DATE OF DEATH 2-1-61			
5. SEX F				6. COLOR OR RACE W			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 2-3-1899			
9. AGE (In years last birthday) 61 yrs.				10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY Education			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel F. Tull				14. MOTHER'S MAIDEN NAME Florence Tull			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. unk			
17. INFORMANT Miss Madeline A. Tull, Norfolk, Va.				Address 316 Fairfax Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured base of skull: crushed chest. DUE TO (b) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Two car collision at intersection Rt. 12 and 354			
20c. TIME OF INJURY Month, Day, Year 4 P.M. 2-1-61				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Highway			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Snow Hill Worcester Md.				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-5-61			
22c. NAME OF CEMETERY Porterville Methodist				22d. LOCATION (City, town, or country) (State) Stockton, Maryland			
23. FUNERAL DIRECTOR Henry A. Watson				ADDRESS Pocomoke City, Md.			
24a. REC'D BY REGISTRAR FEB 7 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02496

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 61 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 1 Ocean City Rd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID		First JENKINS		Middle WARD		Last WARD		4. DATE OF DEATH 2		Month 18		Day 19		Year 1961	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 17, 1871		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Wm. F. Ward		14. MOTHER'S MAIDEN NAME Sarah Wimbrow													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT D.J. Ward		Address , Salisbury, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary artery Heart Disease DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aneurysm of Thoracic Aorta		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 year									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury		(County) Wicomico		(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 2/20 19 61 , to 2/19 19 61 , that (I) (we) last saw the deceased alive on 2/18 19 61 , and that death occurred at 1:00 M, from the causes and on the date stated above.		22a. SIGNATURE David J. Gilmore		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 2-20-1961		22c. PHYSICIAN'S NAME (Type) David J. Gilmore		22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-21-1961		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) Salisbury, Maryland		(State) Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland		ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR FEB 24 '61		25b. REGISTRAR'S SIGNATURE Arthur L. K...									

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2521

CERTIFICATE OF DEATH

Reg. Dist. No. 12487

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>19X</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>D.</u> Last <u>Webster</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4-1960</u>
9. AGE (In years last birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>3</u> Hours <u>—</u> Min. <u>—</u>	11. IF UNDER 24 HRS. Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JABEZ WEBSTER</u>		14. MOTHER'S MAIDEN NAME <u>MARY B. HASHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Jabez Webster</u>		Address <u>Deal Island Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754-4</u> DUE TO <u>Congenital Heart Disease</u> (b) <u>(Subendocardial Fibroelastosis)</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchiolitis</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/29</u> , 19 <u>61</u> , to <u>2/7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>61</u> , and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. J. C. Teller</u>		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>2/7/61</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Maryland</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-9-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>	22d. LOCATION (City, town, or county) (State) <u>Deal Island Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Webster</u>		24a. REC'D BY REGISTRAR <u>Feb 10 '61</u>	
ADDRESS <u>Deal Island</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. D. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DRAIN

1931

THE STATE OF MASSACHUSETTS
COUNTY OF [illegible]
TOWN OF [illegible]
BEFORE ME, the undersigned authority, on this [illegible] day of [illegible] 1931, personally appeared [illegible] known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this [illegible] day of [illegible] 1931.
[illegible]
[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2522

02498

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 210 W. Main St.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETHEL Middle MAE Last WHITE		4. DATE OF DEATH Month 2 Day 7 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-7-1885
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 2 Days 7 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY Clerk	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elihu W. White		14. MOTHER'S MAIDEN NAME Annie Elizabeth Downing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-7258	
17. INFORMANT Mrs. Jean Smith, Middle Blvd., Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Disease 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 13 19 61 to 2/7/61 19 61 , that (I) (we) last saw the deceased alive on Jan 13 19 61 , and that death occurred at 6:20 P.M. the causes and on the date stated above.			
22a. SIGNATURE Carrie I Hearn		22b. DATE SIGNED 2-8-1961	
22c. PHYSICIAN'S NAME (Type) Dr. Carrie I Hearn		22d. ADDRESS 226 N. Division St., Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-9-1961	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland Norman T. Baker		25a. REC'D BY REGISTRAR FEB 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hearn			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2289

NAME

LAST

FIRST

DATE OF BIRTH

SEX

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

SEX

DATE

PLACE

NAME OF PHYSICIAN

NAME OF CLERK

NAME OF REGISTRAR

NAME OF

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2523 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02499

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Fruitland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Box 157			
3. NAME OF DECEASED (Type or print) Pettes Mathew White				4. DATE OF DEATH 2-17-61 19 19			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1933		9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salvor				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Charles Corbin				14. MOTHER'S MAIDEN NAME Jessie Corbin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Jessie Corbin Address Box 157	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull & cerebral 903.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) contusion severe DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell from truck while loading at sawmill.					
20c. TIME OF INJURY Month, Day, Year 11 A.M. 2-17-61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sawmill		20f. (City or town) Fruitland	(County) Wicomico	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 2-20-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/22/1961		22c. NAME OF CEMETERY OR CREMATORY Green acres		22d. LOCATION (City, town, or country) (State) Salisbury Md.	
23. FUNERAL DIRECTOR Clinton S. Stewart				ADDRESS Salisbury Md.		24a. REC'D BY REGISTRAR DATE FEB 24 '61	
				24b. REGISTRAR'S SIGNATURE Clinton S. Stewart			

HEALTH UNIT

8283

CERTIFICATE OF DEATH

Alameda

Alameda

Alameda

Alameda

Alameda

Continental General Hospital

2-17-61

Alameda

Alameda

Alameda

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Well from truck while looking at assembly

Alameda

Alameda

2-17-61

2-17-61

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Alameda

Alameda

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2524

02500

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> d. STREET ADDRESS <u>Calvary Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>James</u> Last <u>Whitman</u>		4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>19 61</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1886</u>	9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marine Railway</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Northhampton County, Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Whitman</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Parkinson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-32-7956</u>		17. INFORMANT Address <u>Mrs. Ethel Whitman--Calvary Rd.--Crisfield, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Rectum</u> <u>154X</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 mon</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I(a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 2</u> , 19 <u>61</u> , to <u>Feb. 8</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb. 7</u> , 19 <u>61</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Lee L. Lawry</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/8/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M. D.</u>		22d. ADDRESS <u>Deer's Head Hospital; Salisbury, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 11, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Crisfield, Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Bradshaw</u>		ADDRESS <u>Bradshaw & Sons</u>		25a. REC'D BY REGISTRAR <u>FEB 14 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in agreement, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

02501

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b X Salisbury (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				d. STREET ADDRESS 1 R.D.# 3 (Walston)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KING Middle WILLIAM Last WORKMAN				4. DATE OF DEATH Month FEBRUARY Day 18 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1883	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months 1 Days 24		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Workman				14. MOTHER'S MAIDEN NAME Elizabeth Hammond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Martha A. Workman (Wife) R.D.# 3 (Walston) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO 450-8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes melitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from now to 2/18/61 , 19 61 , that (I) (we) last saw the deceased alive on 2/18/61 19 61 , and that death occurred at 2:35 P M, from the causes and on the date stated above.							
22a. SIGNATURE Fred R. Gramse				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE Feb. 19/1961	
22c. PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse				22d. ADDRESS S. Division St. Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 21, 1961		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery (Walston) R.D.# Salisbury, Md.		23d. LOCATION (City, town, or county) (State) 	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE FEB 21 '61	
						25b. REGISTRAR'S SIGNATURE Arthur E. Hanna	

RETURN OF INCOME

2000

1040

INCOME TAX

2000

(Name of taxpayer)

(Name of taxpayer)

(Address of taxpayer)

(Address of taxpayer)

(City and State of taxpayer)

(City and State of taxpayer)

(Occupation of taxpayer)

(Occupation of taxpayer)

(Social Security Number of taxpayer)

(Social Security Number of taxpayer)

(Date of filing)

(Date of filing)

(Signature of taxpayer)

(Signature of taxpayer)

(Date of signature)

(Date of signature)

(Preparer's name)

(Preparer's name)

(Preparer's address)

(Preparer's address)

(Preparer's city and state)

(Preparer's city and state)

(Preparer's occupation)

(Preparer's occupation)

(Preparer's social security number)

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(Preparer's city and state)

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